Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 6-12-03.

I. DISPUTE

Whether there should be reimbursement for CPT Code 25115, 13132 and ambulatory surgical care services.

II. FINDINGS

a. On June 25, 2003, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

b. On 3-26-03, the requestor billed CPT code 25115 radical excision of bursa, synovia of wrist or forearm tendon sheaths at $1012.00. He was paid $00.00. The respondent reduced payment based upon, "G-This procedure is incidental to the primary procedure, and does not warrant separate reimbursement." The amount in dispute is $1012.00.

The requestor failed to submit medical records to support fee dispute and support position that charges were in accordance with MFG per Rule 133.307(g)(3)(B).

c. On 3-26-03, the requestor billed CPT code 13132 repair complex hands 2.6 cm to 7.5 cm at $526.00. He was paid $0.00. The respondent reduced payment based upon, "N – Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge." The amount in dispute is $526.00. The requestor failed to submit medical records to support fee dispute and support position that charges were in accordance with MFG per Rule 133.307(g)(3)(B).

d. On 3-26-03, the requestor billed $2,657.25 for outpatient services rendered at ___. The insurance carrier paid $1260.00. The respondent reduced payment based upon, "M – This charge exceeds usual and customary."

Section 413.011(b) of the Act states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in

establishing the fee guidelines." The requestor did not submit documentation to support amount billed was fair and reasonable and complied with Section 413.011(b).

III. RATIONALE

The requestor failed to submit medical records in accordance with Rule 133.307(g)(3)(B) and Section 413.011(b) to support fee dispute and challenge insurance carrier's position.

IV. DECISION

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is not** entitled to reimbursement for CPT code 25115, 13132 and ambulatory surgical care services.

The above Findings and Decision are hereby issued this 7th day of January 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division